Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVIORAL HEALTH
5555 FREDERICKSBURG ROAD 102
SAN ANTONIO TX 78229

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-10-5195-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This program was approved on 1/15/10 (authorization #1044005). These claims were submitted correctly, with the original HICF 1500 form, **4 group** notes, and physical therapy notes supporting **4 hours** in which he participated for **each date of service**. [Claimant] participated 8 hours on each day." "Partial payment was received for the above mentioned dates of service on 4/19/10. These dates of service were paid incorrectly. Carrier disputes the documentation provided did not support the 8 hours and only paid for 4 hours for each date of service."

Amount in Dispute: $3200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has failed to submit additional documentation to support the total of 8 hours per day spent in a chronic pain management program."

Response Submitted by: SORM, P.O. Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2, 2010 February 17, 2010 February 18, 2010 February 19, 2010	Chronic Pain Management – CPT code 97799-CP (8 hours)	$800.00/day X 4 = $3200.00	$00.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 30, 2010
   - W1-Workers compensation state fee schedule adjustment.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - Recommended payment for only 4 hours due to attached docs only support this time spent for each date. Unable to determine additional hours on reconsideration.

Issues

1. Did the submitted documentation support the number of hours billed?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the chronic pain management service based upon reason codes "W1-Workers compensation state fee schedule adjustment"; and "Recommended payment for only 4 hours due to attached docs only support this time spent for each date. Unable to determine additional hours on reconsideration."

   The requestor states in the position summary that "[Claimant] participated 8 hours on each day."

   The requestor submitted the following documentation to support billed services:

DATE	DOCUMENTATION	SIGNATURE	NO. OF HRS DOCUMENTED
February 2, 2010	Daily Group Progress Note (9-10) Daily Group Progress Note (10-11) Daily Group Progress Note (1-2) Daily Group Progress Note (2-3)	Andrea Zuflacht, M.S., LPC	4
	Therapeutic exercises (9:15 – no end time listed)	Scott Summers, PT	0
February 17, 2010	Daily Group Progress Note (9-10) Daily Group Progress Note (10-11) Daily Group Progress Note (1-2) Daily Group Progress Note (2-3)	Andrea Zuflacht, M.S., LPC	4
	Therapeutic exercises (9:10 – no end time listed)	Scott Summers, PT	0
February 18, 2010	Daily Group Progress Note (9-10) Daily Group Progress Note (10-11) Daily Group Progress Note (1-2) Daily Group Progress Note (2-3)	Andrea Zuflacht, M.S., LPC	4
	Therapeutic exercises (9:30 – no end time listed)	Scott Summers, PT	0
February 19, 2010	Daily Group Progress Note (9-10) Daily Group Progress Note (10-11) Daily Group Progress Note (1-2) Daily Group Progress Note (2-3)	Andrea Zuflacht, M.S., LPC	4
	Therapeutic exercises (9:10 – no end time listed)	Scott Summers, PT	0

The Division finds that the requestor did not support billing for the four hours of therapeutic services. The requestor listed the times that the therapeutic exercises began but not when they ended. Furthermore, the claimant was attending treatment with Andrea Zuflacht, M.S., LPC, at the same time as treatment with Scott Summers, PT. The documentation does not support billing. As a result, additional reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support additional reimbursement sought by the requestor. The Division concludes that the requestor did not support its position that additional reimbursement is due. As a result, the amount ordered is $00.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		4/25/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.